2015

EDN AD Waiver Training

JUNE 2015

REBECCA KEMPKES AND MAY FAITH

Department of Health & Human Services
DHHS
NEBRASKA

Contents

Purpose

The purpose of this guide is to provide clarification to A&D Waiver questions commonly asked by EDN Service Coordinators. It is not a comprehensive list of all steps that need to be followed to enroll a child in the A & D Waiver and is not meant to take the place of the A&D Waiver Regulations or the CONNECT instruction manual.

A&D Waiver Overview

Points of Waiver Eligibility

To be eligible for the Medicaid Aged and Disabled Waiver each child/client must:

- Be eligible for Medicaid
- Meet Nursing Facility level of care criteria
- Participate in an in-person assessment with a Services Coordinator
- Need one or more waiver services to safely reside at home
- Have a Plan of Services and Supports / Individualized Family Service Plan which is cost-effective and ensures health and welfare
- Choose waiver services rather than Nursing Facility admission

A&D Waiver Regulations and Instructions

Regulations for the A&D Waiver are in 480 NAC, Chapter Home and Community Optional Targeted Case Management and can be found on the internet at http://dhhs.ne.gov/Pages/reg_regs.aspx The CONNECT Manual for Waiver can be found at the bottom of the CONNECT main menu page.

Identifying Need for A&D Waiver Services / Services Request:

When the EDN case is opened, the EDN Services Coordinator should ensure the child's family is aware of the A&D Waiver and the services it has to offer. Waiver Services should not be formally requested until the family is ready to receive in home services.

A&D Waiver services can be opened at the same time the EDN case is opened or at a later date. If the waiver case is opened in the middle of the EDN eligibility year, the waiver eligibility year may be shortened to correspond with the EDN eligibility year.

CONNECT Information: A Waiver Case page should not be opened in CONNECT until the child/family is actually ready to receive in home services.

Medicaid Eligibility

At the time of a formal request for services, if the child is not currently on Medicaid, the Services Coordinator should inform the parents they must apply for Medicaid. This can be completed online at www.accessnebraska.ne.gov, or over the phone (855) 632-7633 by asking for a paper application. When applying for Medicaid indicate on the application in the notes section A&D Waiver program for children. For **Waiver eligible children**, the parent's income in not counted when applying for Medicaid.

Parents should be advised, A&D Waiver Services cannot begin until Medicaid has started, and all points of AD waiver eligibility are established.. To help facilitate the Medicaid Application, encourage the family to have a copy of the primary insurance card, copy of the child's Social Security Card and Birth Certificate. A paper copy can be submitted with the paper application or uploaded to the application on the ACCESSNebraska website.

The Service Coordinator should be in contact with a Nebraska Department of Health and Human Services (DHHS) Social Services Worker (SSW) through the (855) 632-7633 phone number to follow up on the Medicaid application and let the SSW know the Medicaid A&D Waiver referral is in process.

The parents can check on the status of their application through the ACCESSNebraska website, under the My Account tab on the ACCESSNebraska Home Page.

The Services Coordinator can verify the client is Medicaid eligible by contacting the SSW, or by looking on the detail program case window in N-FOCUS.

In some cases, Medicaid eligibility is contingent on waiver eligibility. This occurs because for a waiver eligible child, the parents' income is not included when applying for Medicaid. In this circumstance, the SC will need to contact the SSW to provide notification the child is eligible for A&D Waiver as soon as they receive certification on the Level of Care. The SC should verify with the SSW the child will be Medicaid eligible once the Medicaid Home and Community Based Services Waiver Consent Form (MILTC-5AD) is signed by the parent.

CONNECT Information: If the child is not already on Medicaid, the Services Coordinator will need to enter the date the Medicaid application was submitted in the "pending" section of the Medicaid Eligibility Status on the Waiver page in CONNECT. Once Medicaid has been approved, the date Medicaid coverage begins will need to be entered in the "opened" box of the same section in CONNECT.

Waiver Referral

A Referral Date should not be documented until the need for A&D Waiver services has been identified, parents have formally requested the service and the child/family is actually ready to receive in home services.

Within 14 days of receiving a referral, the Services Coordinator will schedule a meeting to do the Needs Assessment, Level of Care and discuss potential services and providers at a time, date and location convenient to the client/family.

Client Assessment

Needs Assessment

The needs assessment is completed at the initial referral and renewal of waiver services. The SC together with the child and family complete the assessment to determine the clients/family's strengths, needs, priorities, and resources.

This assessment is the basis for the development of the client's Plan of Services and Supports (POSS). Plan of Services and Supports: A process for providing services and supports that takes into consideration each client's strengths, needs, priorities, and resources and results in an individualized, written plan for each client. This plan describes the full range of services to be furnished (regardless of funding source), their frequency, and the type of provider who will furnish each.

Waiver requires a Plan of Services and Supports (POSS) for each client. For EDN children, POSS requirements are incorporated into the IFSP. Any reference to "Plan" or "POSS" in the regulations or CONNECT manual instructions would actually pertain to the IFSP for EDN waiver children.

The Assessment is documented on the **IFSP Cover Page, Needs and Priorities Page, Strengths Page and the Present Level of Development / Abilities Page**. The assessment is about gathering information, not filling out a form, but the form is how the information is documented.

Information for the assessment should be gathered from

- Parents
- Medical records from the most recent 6 months
- Service Coordinator observations
- Educational reports
- Any other source identified

The evidence should be consistent across all information and from each source. The Assessment should include the child's current abilities and health needs.

IFSP Cover Page – documents the family's contact information and relative information about the client.

Needs and Priorities Page must reflect

- the date the family formally requested in home waiver services
- resources the family may already have to assist in meeting the family's needs
- identify the medical needs which would qualify the child for the waiver
- document the need for Services Coordination
- reflect the family's needs/priorities that could be met by Waiver
- the need for each specific waiver service requested
- identify educational and other priorities of the family

The Present Levels of Development section should contain information on Vision, Hearing, Health Status, Cognitive / Thinking Skills, Communication Skills, Social / Behavior Skills, Self Help / Adaptive Skills, Fine Motor Skills, and Gross Motor Skills

Initial Assessment for a Waiver Referral – The meeting with the family, family members, advocate or people outside of the family as requested by the family and the services coordinator must take place within 14 days of the Waiver referral. At this meeting the Waiver Assessment is completed.

> If EDN services are already in place, a waiver "intake" meeting would need to be held within 14 days of the AD Waiver referral, to include waiver specific information in the IFSP; this meeting can be between the SC and the family to assess the family's needs.

Assessment for AD Waiver Renewal – Prior to submitting a new Level of Care to the Program Specialist – Pediatric Nurse for approval you must meet with the family, and individuals requested by the family to reassess the client's needs.

Ongoing Assessment – Every time you meet with the client, and their family the Services Coordinator should be assessing their needs to see if there is an improvement or decline in health that would require a change in services.

CONNECT Information: The date of the Pre-IFSP/periodic meeting will be entered as the Initial Assessment Date in CONNECT. Per CONNECT Instructions if the Initial Assessment Date is greater than 14 days from the referral date, a Reason for Delay will need to be entered in the dropdown box in CONNECT and in the narratives. The initial assessment date is only entered at the time of the initial assessment. It will not be changed when reassessments occur.

Level of Care

Client must meet Nursing Facility Level of Care (LOC) to receive Waiver services. LOC Determination is completed prior to case opening, when a change in condition that may affect eligibility occurs, or annually while on waiver.

Local SC staff meet with the child's parent/guardian to assess needs and gather information. Information can be gathered from Parents, Medical records from the most recent 6 months, Service Coordinator Observations, Educational reports, any other source. The SC submits a LOC recommendation via CONNECT and supportive documentation to Central Office Program Specialist – RN for final LOC approval.

The Level of Care Criteria varies by age; factors are weighted differently given expected developmental functioning. LOC is determined by looking at:

- Health assessment (diagnosis, cognitive status)
- Medical treatments and therapies
- Activities of Daily Living (ADLs) (considered after 36 months of age)
- Other considerations (behavior, vision, hearing, communication)

Home and Community-Based Waiver
MILTC-13AD, Child's Level of Care

Section 1 - Type of Waiver

Waiver Type: EDN Review

Section 2 - Demographics

Child's/Client's Name: Gardner, Elanor
Date of Birth: January 26, 2014
Social Security Number: 978-05-4400
Medicaid pending: NO
Medicaid Number: 234567891-01
Date Medicaid Approved: September 20, 2014

Section 3 - Health Assessment

Record child/client diagnosis, if known. Please state if no diagnosis has been determined.

Diagnosis Notes: Child has cancer
Cognitive Status: child is receiving EDN services to help keep them on track developmentally.
Recent Height: 0 ft. 0 in. (0.0%)
Recent Weight: 0 lbs. 0 oz. (0.0%)

Section 4 - Medical Treatements and Therapies

Venous access/central line: Intravenous line for long-term treatment: Can be used to give medications, IV fluids in the home, nutrients and obtaining blood specimens, or if the client has limited peripheral venous access due to extensive previous IV therapy, surgery, or previous tissue damage. Examples: broviac, hickman, groshong catheters; implanted ports (port-a-cath, infuse-a-port, norport, proshong port); PICC lines (peripheral central line).

Justification: Has an infusaport for IV chemotherapy every month and labwork weekly

IV Therapies: Daily intravenous therapy for the administration of fluids, nutrients, and/or medications. May include a main continuous intravenous infusion therapy; or an intermittent infusion device such as a heplock (for administration of periodic IV medications and solutions without continuous intravenous infusion) or an "IV Piggyback" infusion (which is used to administer medications via the fluid pathway of an established primary infusion line).

Justification: Receives TPN via port every night from 10pm to 6am.

Determination of the Medical Treatments/Medical Therapies

Client does have a medical treatment/therapy need.

Section 5 - Activities of Daily Living (N/A 0-36 Months) * = Dependent

Determination of the ADL Category
Determination: Low

Section 6 - Other Considerations * = Dependent

Determination of Other Considerations
Determination: Low

Section 7 - Recommendation

I. Medical Treatments/Therapies (1-9) Must have at least one

Services Coordinator: Kempkes, Rebecca
Recommendation Date :
Submit Date :
Email Address: rebecca.kempkes@nebraska.gov
Phone # (402) 471-1678
SC Agency: Good Samaritan Hospital

Section 8 - Justification and Certification

Justification:
I certify that this client does not meet the criteria for NF level of care.
Signature: ,
Certification Date :

In order to meet Nursing Facility Level of Care criteria, a child must require specific intervention to prevent a decline in health status in one or more of nine medical treatment / therapy categories.

1. **Venous Access / Central Line:**
    a. Intravenous line for long term treatment which must be used to give
        i. Intravenous line for long term treatment
        ii. Medications
        iii. IV fluids in the home

iv. Nutrients
v. Obtaining blood specimens
vi. If the client has limited peripheral venous access due to extensive previous IV therapy, surgery or previous tissue damage

b. Questions to Ask
i. Medications
ii. IV fluids in the home
iii. Nutrients
iv. Obtaining blood specimens
v. If the client has limited peripheral venous access due to extensive previous IV therapy, surgery or previous tissue damage

c. Submit doctors notes

2. **IV Therapy / Infusion** – Daily intravenous therapy for the administration of fluids, nutrients, and/or medications. May include a main continuous intravenous infusion therapy, or administration of IV medication and solutions without continuous intravenous infusion.
   a. Questions to ask
      i. What is medication or fluid?
      ii. When was it started?
      iii. What is its purpose?
      iv. How often is it used?
      v. Who does it?
      vi. How long is treatment expected?
   b. Submit documented treatment plan

3. **Wound / Skin Care** – Application of aseptic dressing and treatment for wounds and aseptic dressing changes.
   a. Medical records must establish
      i. The physician or nurse has documented the presence of a wound
      ii. A written wound treatment plan has been developed
      iii. Progress notes indicating the client's response to treatment has been recorded by licensed nurses, and the physician has documented periodic reassessment of the state of treatment of the wound and determined the need for continued wound care
   b. Questions to ask
      i. The physician or nurse has documented the presence of a wound
      ii. A written wound treatment plan has been developed
      iii. Progress notes indicating the client's response to treatment has been recorded by licensed nurses, and the physician has documented periodic reassessment of the state of treatment of the wound and determined the need for continued wound care
   c. Submit documented treatment plan

4. Catheterization/Sterile Irrigation – Includes daily intermittent catheterization
   a. Indwelling catheter requiring daily care
      i. emptying and monitoring of input and output

ii. catheter irrigation.

b. Questions to ask
   i. How often during the day is the procedure done?
   ii. Who does the procedure?

c. If the child can independently perform their own self catheterization care and maintenance, this category does not apply.

d. Submit medical notes

5. **Dialysis At Home** – The child is receiving Peritoneal Dialysis at home on a Daily Basis
   a. Questions to ask
      i. When is the procedure done?
      ii. How often is the procedure done?
      iii. How long does the procedure take?
      iv. Who does the procedure?
   b. Submit documented treatment plan

6. **Tube Feeding** – Daily administration of foods, liquids, and medication. Tube is the primary source of nutrition.
   a. Questions to ask
      i. What kinds of tube is being used?
      ii. What foods, fluids or medication are being given through the tube?
      iii. Are the feedings given by bolus or continuous drip?
      iv. How often is it being used?
      v. Are there any night feeds?
      vi. Who does the tube feeding?
      vii. Is the child taking any foods or liquids orally? How much?
   b. If child can independently perform their own tube feeding and care for their tube, this category does not apply
   c. Documentation needed
      i. Percentage of child's needs supplied by tube feedings
      ii. Give specific type and amount of food/formula
      iii. Dietician/medical note stating: Daily caloric needs and percent supplied in a tube feeding specific amount
      iv. Schedule of feedings

7. **Nasopharyngeal Aspiration And Throat Suctioning** – Child is receiving daily Nasopharyngeal, tracheostomy or throat suctioning utilizing a suction machine with tubing, suction catheters, and normal saline.
   a. Questions to ask
      i. What kind of suctioning is being done?
      ii. How often is it being done?
      iii. Who does the suctioning?
   b. Submit medial notes

8. **Unstable Medical Condition** – requires daily clinical monitoring, observation, complex nursing interventions, and reporting of signs and symptoms to a physician
    a. Child's condition requires re-evaluation by nurse or physician
    b. Current medical records must be submitted to support the client's condition.
    c. Examples of Unstable Medial Condition
        i. Active / terminal cancer
        ii. Acute spinal cord injury
        iii. Cerebrovascular accidents (CVA) – stroke
        iv. Congenital heart disease (pre/postoperative)
        v. Uncontrolled respiratory condition
        vi. Uncontrolled seizure disorder
        vii. Post-transplant complications
        viii. Severe spastic quadriplegic cerebral palsy with other medical issues
        ix. Ventriculoperitoneal (VP) shunt malfunctions, occlusions infections resulting in frequent hospitalization / increased medical interventions
    d. Submit medical documentation including information on recent hospitalizations or medication/treatment changes.

9. **Narcotic And Controlled Substance** – Chronic pain management program with daily or frequent prn routine narcotic analgesics
    a. Questions to ask
        i. What medication is given?
        ii. When was it started?
        iii. What is its purpose (reason for medication)?
        iv. How often is it used?
        v. Have there been any recent hospitalizations or medication changes for symptom control?
    b. Submit documented treatment plan

The information needed for the level of care is gathered during the assessment (IFSP) from interviews with family, professional observation, medical reports and school reports. The Services Coordinator will complete the Level of Care in CONNECT and upload the following in CONNECT:

- IFSP Cover Page
- Needs / Priorities Page of the IFSP
- Strengths Page
- Present Levels of Development/Abilities page of IFSP
- Medical Documentation

Once all the documentation has been uploaded to CONNECT, send an email to the Program Specialist – RN at DHHS.ChildrensLOC@Nebraska.gov, to inform them of the location of the information.

The Program Specialist – RN will communicate with SC via email and will leave instructions in the CONNECT Case regarding Level of Care. Section 8 the Justification and Certification section of the Level of Care will contain the reasons why the client qualifies for NF LOC, and notes regarding the next

assessment including information on the assessment due date. When a LOC is certified, the Program Specialist – RN will generate an authorization email for the SC to place in the child's file.

A copy of the Level of Care will need to be placed in the file. If the Level of Care is not certified an HHS-6 will need to be submitted. Please see section on Notifying of Adverse Actions for more information regarding HHS-6.

Waiver Eligibility is re-determined with any change in condition that may affect eligibility, at a minimum annually. For a scheduled redetermination submit the LOC Documentation 45 days prior to the end of the current eligibility period.

> Example, if the eligibility is from September 1 – August 31, the LOC documentation would need to be submitted on July 15.
>
> Example, if the eligibility is from September 1 – March 31, the LOC documentation would need to be submitted on February 15.

This gives the Pediatric Nurse time to review the documentation, and request more information / justification if necessary, and time for a Notice of Adverse Action to be sent timely if the child no longer meets nursing facility level of care. The Pediatric Nurse will not approve the LOC until the month it is due. If submitting LOC documentation outside a scheduled redetermination let the Pediatric nurse know why you are submitting the information.

If the LOC is not certified an HHS-6 will need to be sent to the family. If the Level of Care has expired, the waiver case needs to close and an HHS-6 sent.

IFSP/Plan of Services and Support (POSS)

IFSP is developed based on assessment information and updated subsequently with changes in client's needs.

Identifies:

- Client's needs
- Client's strengths
- Client's priorities
- The amount, type, duration, scope and frequency of services to meet the needs
- Signifies the person or persons responsible to meet those needs
- Must ensure the client's safety, health and welfare

Together with the child and family, the services coordinator further develops the IFSP by identifying desired client outcomes. The IFSP must ensure the child's health and welfare, including consideration of acceptable risk. If despite consideration of the full range and scope of services, the child's health or welfare is in jeopardy, waiver services may not be authorized.

The IFSP must document the waiver services to be authorized. THE CHILD'S GUARDIAN HAS FREEDOM OF CHOICE IN SELECTING PROVIDERS OF WAIVER SERVICES. All providers must meet provider eligibility standards.

Copies of the IFSP are distributed to the IFSP team with the consent of the child's guardian

IFSP Waiver Outcomes

IFSP needs an outcome related to the medical condition or treatment that is qualifying the child for waiver and an outcome related to each waiver service or need (such as child care, respite, of nutrition.)

IFSP Action Steps

Action steps state how the waiver service will help achieve the outcome statements. Action steps are documented in "what will be done by whom" section of the IFSP. Action Steps must correlate with the outcome, address all needs identified in the Level of Care and Assessment, include SC activities that are single action activities, include informal / non-paid services, and formal / paid services.

Action Steps:

- Document the specific need of each child and what the provider is going to do
- Include strategies to mitigate identified risks.
- Include a back-up plan, when a provider is unavailable or does not show up. Parents may choose to not have a backup provider, this should be documented
- Disaster or emergency plan (weather, loss of power, catastrophic event), reflect details that need to be considered in the event of a natural disaster if the child has a related identified need (e.g., electricity for equipment, access to sufficient medical supplies).

IFSP needs to document a safe plan. If the IFSP cannot assure the health and welfare of the child, waiver services will not be provided.

After a safe IFSP has been developed, the Medicaid case has been opened and the Level of Care has been certified; the SC will have the parent sign the Medicaid Home and Community Based Waiver Consent Form (MILTC-5AD). The date the consent form is signed is the Case Open Date. When the case is open on the IFSP Service Page "Medicaid Waiver" can be listed as the payment source.

Consent

Once the Level of Care has been certified, the Medicaid Case is open and a safe cost effective plan has been developed offer the client's parent/guardian the option of accepting nursing facility or waiver services as described in the IFSP. If the parent/guardian chooses to accept waiver services, the services coordinator shall obtain the proper signature on the Medicaid Home and Community Based Services Waiver Consent Form (MILTC-5AD). The client's waiver eligibility period may begin no earlier than the date of the client/guardian's signature on the consent form.

Waiver Eligibility Period

The Waiver Case opens when all points of Waiver eligibility have been established: IFSP, LOC Certified, Active Medicaid Case, Consent signed. The Waiver eligibility period cannot exceed 12 months, or the certification date on the Level of Care. The waiver eligibility period can be shortened to match the EDN eligibility year.

Cap Worksheet

The Cap Worksheet is used to document the plan for specific Medicaid and Waiver services and to estimate the monthly cost of the plan. The function of the cap worksheet is two-fold: to document the

plan to provide specific Medicaid non-waiver and Medicaid waiver services and to determine the estimated total monthly cost of the plan.

Cost Effective is a requirement that the expenditures reflected on the cap worksheet, derived from the IFSP be within the average Medicaid monthly expenditure for care in a nursing facility. This is referred to as the cap. The cap worksheet will calculate the monthly costs for an individual to help determine if the plan is cost-effective. Waiver populations have set caps (maximum waiver expenditures). If there is a need to exceed the authorized cap the Services Coordinator needs to contact DHHS Central Office for approval / denial.

The ongoing cap may change annually. As of October 2014 the current monthly cap amounts are $4,200 for all ages, $7,000 for Partial Vent, $11,000 for Complete Vent. Any amount over these budget allowances requires a cap exception. There are three types of exemptions:

1. Ongoing
2. Update – condition deterioration, needs nursing service, informal caretaker hospitalized or correction in the cap worksheet amount
3. Time Limited – caregiver going on vacation, or needs increased for limited time

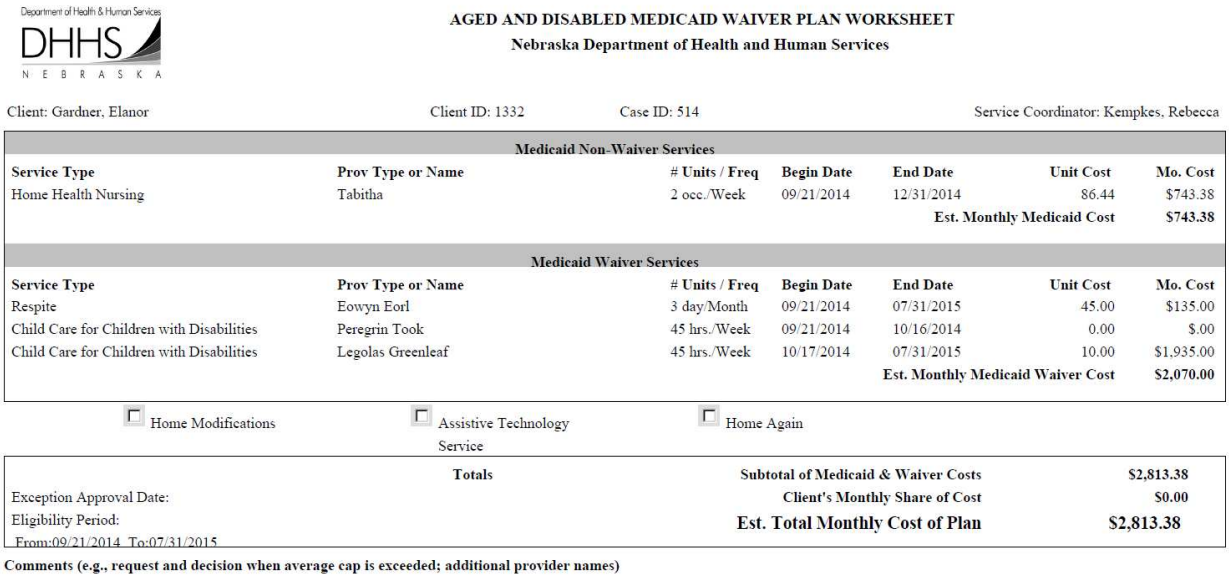
If the estimated monthly cost of the plan of services and supports or the IFSP exceeds the ongoing cap, the services coordinator shall contact HHS Central Office, Program Specialist –RN Denise Woolman to discuss possible approval to exceed the ongoing cap. Before contacting the Program Specialist – RN regarding a request for an exception please make sure you have an updated Level of Care, and Cap Worksheet on CONNECT with information explaining why the exception is needed, the total monthly budget amount needed and the amount of time the exception is needed for.

The cap worksheet is completed when eligibility (LOC) is updated and as needed with client service changes. Only one cap worksheet can be in place for a case for any given time period; no month may overlap. To enter a new cap worksheet you need to know the waiver eligibility period. For each service, you need to enter the type of service, provider type / name, number of units/frequency, Begin Date, End Date and Unit Cost

The Services Coordinator will work with the Resource Developer in their DHHS Service Area to obtain provider rates for service authorization and related information such as parental obligation for child care.

When services change during the eligibility period, the cap worksheet and the plan need to be updated. CONNECT does not store a history when the cap worksheet is revised during an eligibility period. When making a change please zero out any unit cost information that is no longer current and then add the new information. If a mistake is made of the eligibility period, please contact Don Severance to have the date corrected.

A new cap worksheet needs to be added for every new eligibility period. Do not edit an existing cap worksheet for use in a new eligibility period.



AGED AND DISABLED MEDICAID WAIVER PLAN WORKSHEET
Nebraska Department of Health and Human Services

Client: Gardner, Elanor | Client ID: 1332 | Case ID: 514 | Service Coordinator: Kempkes, Rebecca

Medicaid Non-Waiver Services

Service Type	Prov Type or Name	# Units / Freq	Begin Date	End Date	Unit Cost	Mo. Cost
Home Health Nursing	Tabitha	2 occ./Week	09/21/2014	12/31/2014	86.44	$743.38
					Est. Monthly Medicaid Cost	$743.38

Medicaid Waiver Services

Service Type	Prov Type or Name	# Units / Freq	Begin Date	End Date	Unit Cost	Mo. Cost
Respite	Eowyn Eorl	3 day/Month	09/21/2014	07/31/2015	45.00	$135.00
Child Care for Children with Disabilities	Peregrin Took	45 hrs./Week	09/21/2014	10/16/2014	0.00	$.00
Child Care for Children with Disabilities	Legolas Greenleaf	45 hrs./Week	10/17/2014	07/31/2015	10.00	$1,935.00
					Est. Monthly Medicaid Waiver Cost	$2,070.00

☐ Home Modifications ☐ Assistive Technology Service ☐ Home Again

Totals		
	Subtotal of Medicaid & Waiver Costs	$2,813.38
Exception Approval Date:	Client's Monthly Share of Cost	$0.00
Eligibility Period: From:09/21/2014 To:07/31/2015	Est. Total Monthly Cost of Plan	$2,813.38

Comments (e.g., request and decision when average cap is exceeded; additional provider names)

CONNECT Information: Medicaid Non-Waiver Services need to be included in the allowable budget in the top section of the cap worksheet. Any fee-for-service Medicaid service not covered by Waiver should be listed in this section e.g. home health aide, home health nursing, medical transportation, personal attendant services, or private duty nursing.

Forms

Waiver forms can be found at the DHHS Nebraska Website www.dhhs.ne.gov by clicking the Download Forms feature.

FA-65

This form may be used by recipients of in-home services from the Nebraska Department of Health and Human Services (DHHS) to make or revoke an appointment for DHHS to act as the employer agent for purposes of making deposits or payments of Nebraska State and Federal employment taxes and other withholding taxes.

The employee's share of Social Security tax is withheld from provider payments only when in-home service is provided by an individual not affiliated with an agency. HHS, upon receiving a signed "Employer Appointment of Agent," acts on behalf of clients who receive in-home services to withhold mandatory FICA taxes from individual providers and pays the client's matching tax share to the Internal Revenue Service (IRS).

Waiver Services

The following services are available for children under the Aged and Disabled Waiver:

1) Child Care for Children with Disabilities (CCCD) –is that portion of child care provided to children related to their medical or disability-related needs. Child care is provided to children from birth through age 17 on the average of less than 12 hours per day, but more than two hours per week on a regular basis, in lieu of caregiver supervision. Care is provided in a child's home by an

approved provider or in a setting approved or licensed by the Department of Health and Human Services. The parent or primary caregiver is responsible for the basic cost of routine child care (Parent Obligation) for kids through age 12. The Aged and Disabled Medicaid Waiver is responsible for the payment of the service above the basic cost of routine child care. The need for this service must be reflected in one or more assessment areas of the child's plan of services and supports. Per regulation 480 NAC 5-005.D

a) Can only be authorized for the following reasons:
   i) For parent(s) to accept or maintain employment
   ii) For parent(s) to enroll in and regularly attend vocational or educational training to attain a high school or equivalent diploma
   iii) For parent(s) to enroll in and regularly attend college courses to obtain their first undergraduate degree
   iv) For parent(s) to seek employment up to 12 hours per week for two consecutive months within any 12 month period.

   (Note: Parents must be absent at the same time, and both parents must be participating in a qualifying activity)

b) Cannot be used in these situations:
   i) If the service is the responsibility of the school system
   ii) To obtain a second undergraduate degree, second certificate, or graduate level or higher degree
   iii) If the parent is not working or attending regularly scheduled classes e.g. parent is home sick, or has taken time off to attend a doctor's appointment
   iv) For the parent to have time to study for class
   v) Sleep time for the parent

c) Important information to gather…
   i) Parent's preference for in-home or out of home child care, the parental obligation varies depending on the licensure requirements for the provider, and the geographical location of the provider
   ii) Parent(s) work or school schedules
   iii) Travel time to and from work or school
   iv) Name of provider(s)

d) Authorization description example

   Provider's hourly rate per agreement signed 10-30-14 is $8.71/hour.
   Up to x hours of child care needed based on parent schedules including commute times.
   Effective 10-30-2014
   Lancaster County – Toddler
   Parental Portion: $ 2.25 /hour
   Waiver Portion: $ 6.46 /hour

Child care services are authorized while both parents are working or attending school simultaneously. MOM'S NAME schedule is Tuesdays, Thursdays, & Fridays from 4:00 pm – 9:30 pm, and Saturdays from 10:00 am – 2:00 pm. Her commute time is 15 minutes one way. DAD'S NAME schedule is Monday – Friday 7:00 am – 6:00 pm and occasional Saturdays. DAD'S NAME commute time varies depending upon location of work as he sometimes works in Gretna. Commute time one way from Lincoln to Gretna is approximately 45 minutes.

Payment of parental portion is between the parent and provider. Please bill monthly.

2) Respite Care – temporary care of an aged adult, adult or child with disabilities to relieve the usual caregiver from continuous support and care responsibilities. Components of respite care service are supervision, tasks related to the individual's physical needs, tasks related to the individual's psychological needs, and social/recreational activities. Respite care may be provided in the individual's home or out of the home. If respite is provided by a hospital or other facility, the individual is not considered a facility resident. The need for this service must be reflected in one or more assessment areas of the client's plan of services and supports. Per regulation 480 NAC 5-005.K

   a) Authorized hours & days should reflect the family's/client's needs. 360 hours or 60 days is the program maximum for an eligibility year. There is no exception process to receive additional respite hours. Services Coordinator will need to monitor use of respite hours.

   b) Common reasons for authorizing Respite:
      i) Parent(s) to have time to run personal errands or attend a doctor's appointment
      ii) Parent(s) needs to have an opportunity to rest or relax away from regular caregiving duties
      iii) Parent(s) need relief to attend regular, prescheduled activities, e.g. PTO/PTA meetings, church, other club meetings, etc.
      iv) To spend individual time with their other children

   c) Situations where respite cannot be used:
      i) For parent/caregiver to accept or maintain paid employment
      ii) For parent/caregiver to pursue a course of study designed to them for paid employment

   d) Respite Care Authorization Description

      i) Include the number of hours and days the client is eligible to receive. For the 12 month eligibility period each client is eligible to receive up to 360 hours or 60 days of service.
      ii) If the provider is an agency, note that daily rates should be billed for 6 or more hours of service provided in a day.
      iii) If the provider is an individual provider only authorize hourly rates.
      iv) Must include a note regarding parental tracking of respite usage to ensure parents do not exceed authorized hours/days for the eligibility year.
      v) Must note that hours are shared amongst all respite care providers if client/family has multiple providers authorized.

3) Nutrition (seldom used for infants and toddlers) - measure indicators of dietary or nutrition-related factors to identify the presence, nature, extent of impaired nutritional status of any type, and to obtain the information needed for intervention, planning, and improvement of nutritional care. The service includes assessment, intervention, including education/ counseling and follow-up. The need for this service must be reflected in one or more assessment areas of the client's plan of services and supports. Per regulation 480 NAC 5-005.I

   a) Nutrition services are limited to 1 initial visit done to assess the client needs

   b) Follow-up visits over the next three months can include menu planning, or education to increase comfort with administering tube feedings

   c) Can request nutrition education be given to the provider as one of the visits

   d) Nutritional Services are to be terminated when the goal is met, or progress is not being made

4) Home Modifications – physical adaptations to the home which enable the client to function with greater independence in the home. Approvable modifications are limited to those which are necessary to maintain the client in his/her home. Per regulation 480 NAC 5-005.G

   Home modifications may include, but are not limited to, the installation of ramps and grab bars; widening of doorways; modification of bathroom facilities; or installation of specialized electric and plumbing systems which are necessary to support assistive equipment.

   The need for this service must be reflected in one or more assessment areas of the client's plan of services and supports.

   a) Appropriate for a child if the adaptation would:
      i) Provide the child access for participation
      ii) Increase the child's endurance or ability to persevere and complete tasks
      iii) Helps the child perform a function and there are no other means
      iv) Supports normal social interactions with peers and adults
      v) Allow the child to move through & interact with the home environment

5) Assistive Technology and Supports (ATS) - specialized medical equipment and supplies which include devices, controls, or appliances which enable a client to increase his/her abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which s/he lives. Approvable items are limited to those which are necessary to maintain the client in his/her home. Per regulation 480 NAC 5-005.C

   The need for this service must be reflected in one or more assessment areas of the client's plan of services and supports.

   a) Appropriate for a child if the adaptation would:
      i) Provide the child access for participation
      ii) Increase the child's endurance or ability to persevere and complete tasks
      iii) Helps the child perform a function and there are no other means
      iv) Supports normal social interactions with peers and adults

v) Allow the child to move through & interact with the home environment

6) Non-medical Transportation – transporting a client to and from community resources identified during client assessment as directly contributing to the ability of the individual to remain at home. Service may be provided by an individual, agency (exempt provider), or by common carrier. This can include the need for an escort during transportation. Per regulation 480 NAC 5-005.L

   The need for this service must be reflected in one or more assessment areas of the client's plan of services and supports

   a) Conditions of Provision
      i) Parent/guardian has no working vehicle
      ii) Parent/guardian has no current driver's license
      iii) Escort can be used if child requires constant supervision

   b) Limitations
      i) Transportation cannot be authorized to obtain educational services for children
      ii) Medical transportation must be covered under Medicaid-fee-for-service

The most commonly used services are Child Care for Children with Disabilities and Respite Care.

Service Authorizations

Services cannot be authorized until the waiver case is opened and providers are approved. The Services Coordinator will work with a Resource Developer (RD) in their DHHS Service Area. Once a family identifies a provider the SC will check N-FOCUS to determine the provider registration with the State of Nebraska. If the provider is not registered with the State of Nebraska, SC will complete a Resource Development Referral (CC-2) and fax/email the form to the HHS-RD in their Service Area. RD Department will work with the provider to initiate the enrollment process, which includes background checks, pay rate negotiation and paperwork, so the provider can be paid. SC should be in contact with their RD, to learn when the provider is approved to provide services and at what rate. SC will create the service authorization once the provider is approved.

Resource Developers recruit and retain quality service providers who meet standards, create choices for clients, train providers in billing process, collaborate with Service Coordinators, and negotiate service provider rates and plan. 480 NAC 5-008 and 5-009

Service Authorizations are created in N-FOCUS, and must identify the client and provider. Service Authorization length cannot exceed 12 months, and the authorization date must coincide with the Waiver Eligibility Period. Each Service Authorization must include a description of the service to be provided, and how the provider should bill, the number of units to be authorized, and the rate authorized with the frequency.

For the EDNs with N-FOCUS Access, the Service Coordinators are responsible for creating the Service Authorization. For the EDNs without N-FOCUS Access, work with the DHHS Services Coordinators in your Service Areas to have the Service Authorizations created.

Example: Child Care Authorization Description

Provider's hourly rate per agreement signed 10-30-14 is $8.71/hour.

Up to x hours of child care needed based on parent schedules including commute times.

Effective 10-30-2014

Lancaster County – Toddler

Parental Portion: $ 2.25 /hour

Waiver Portion: $ 6.46 /hour

Child care services are authorized while both parents are working or attending school simultaneously. MOM'S NAME schedule is Tuesdays, Thursdays, & Fridays from 4:00 pm – 9:30 pm, and Saturdays from 10:00 am – 2:00 pm. Her commute time is 15 minutes one way. DAD'S NAME schedule is Monday – Friday 7:00 am – 6:00 pm and occasional Saturdays. DAD'S NAME commute time varies depending upon location of work as he sometimes works in Gretna. Commute time one way from Lincoln to Gretna is approximately 45 minutes.

Payment of parental portion is between the parent and provider. Please bill monthly.

Billings

All home and community-based services (HCBS) waiver providers are Medicaid providers and shall meet Medicaid provider standards. Providers shall bill only for services which are authorized and actually provided and submit billing documents after service is provided and within 90 days. Billing documents are submitted to the Services Coordinator. The Services Coordinator reviews the billing documents for errors. If there are errors on the documents, the provider must fix the documents before the SC can sign and submit them for payment. Documents are submitted to DHHS N-FOCUS Billing via email at dhhs.N-FOCUSbillingdocuments@Nebraska.gov or fax at (402) 471 – 7783 or via mail at DHHS N-Focus billing, Attn: Janell Svoboda, P.O. Box 95026, Lincoln, NE 68509.

Document Review

Things to review before submitting the billing documents to N-FOCUS Billing. There are two billing documents, the N-Focus Billing Document DHHS-5N and Individual Provider Record of Services MC-37-ES. Both documents must be reviewed and error free before submitting to N-FOCUS Billing

Key items to focus on:

- Is the provider an authorized service provider?
- Was the Service Authorization active for all dates being billed?
- Is the provider billing for hours/time frames the parents have stated are their scheduled work or school hours? (This applies to child care bills only).
- Is the rate entered on the N-FOCUS billing document the total rate charged for the service? (For child care this would be the total of the waiver portion and parental portion).
- Do the rates match what is currently in the provider agreement or most current service authorization?
- For Child Care, is the customer obligation column completed? This column reflects what would be paid by the family as the routine cost of child care.
- Is the client/guardian signature date after to the final date worked?

- Are a.m. and p.m. clearly marked on the Individual Provider Record of Services?
- Are the correct service codes listed?
- Was the child hospitalized or out of the home for any period of the provider is billing for?
- Was the provider hospitalized or institutionalized for any on the dates listed on the billing document?

Best Practices

- Ensure all billing documents received have a "received" date noted on them somewhere. This helps you know when something made it to your office in the event questions arise later.
- Correct Billing documents must be submitted within 3 days of receipt.
- If you must send something back to a provider, keep a copy and note the date you put it outgoing mail/email. This will help for tracking purposes and ensure a copy is maintained in the event that one is lost in mailing. Not all providers keep a copy of what they send to you.
- Many providers prefer to be called and schedule a time to come in to make corrections. Not all providers live locally so this may not be an option.

N-FOCUS Billing Document DHHS-5N

DHHS NEBRASKA

N-FOCUS BILLING DOCUMENT

All billings must be received within ninety (90) days of service provision

Claim Number: 1111111

Date: 09/16/14 TO 09/30/14

DHHS Provider ID: 123456789

Office No: 403 Office Name: LPS

Phone Number: 402-111-1111

Provider Name:
CLARINDA HAPPY
1234 HUSKER WAY
LINCOLN, NE 11111

By signing this form, the claimant certifies that the information contained in this claim is accurate and all services provided were in compliance with Department of Health and Human Services Nebraska Administrative Codes Titles 465, 471, 473, 474, and 480, whichever are applicable. The claimant is aware that a false claim may result in prosecution for fraud. Under penalty of applicable Federal and State Laws, I certify that representation herein are true and complete, and that no additional payment will be claimed.

Ln	Client Name	Client ID Number	Authoriz. Number	Service Code	Service From Date	Service Thru Date	Freq	Units	Rate	Total Charge	Cust Oblig	DHHS Charge
1	Doe, John	12345	1234567	2500	9-16-14	9-30-14	HR	60	$13.42	805.20	$120.00	$685.20
2	Doe, John	12345	7654321	1113	9-16-14	9-30-14	HR	2	8.71	17.42		17.42
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												

Provider/Preparer Signature	Signature Date	Service Approval Signature	Approval Date	Total DHHS Charge
Clarinda Happy	9-30-14			$702.62

For information about the status of your claim, call ACCESSNebraska at 1-800-383-4278. For information regarding where to submit your claim see the reverse of this form.

DHHS-5N Rev. 10/11

- All areas must be completed
- Many areas will be pre-printed for the provider on the N-FOCUS Billing Document including the office number, office name, provider name, provider phone number, provider ID number and claim number in addition to other areas that are not highlighted yellow.
- Pay special attention to be sure the date line at the top of the form is completed, and service from and thru dates are filled in.
- The total number of units, the rate, customer obligation, and DHHS charge as well as the total DHHS charge must all be completed.

- There MUST be a provider signature and date. The family/parent cannot sign the document for the provider.
- If any of the yellow highlighted areas are blank the billing document must be returned to the PROVIDER and ONLY the provider for correction and re-submission. SCs and families cannot complete any changes to the document as the document certifies the hours the provider states they provided service. Anyone else altering the document alters this certification by the provider.
- A provider CANNOT bill for more hours than they are authorized. If a provider may only bill a 30 hours per month then there should be no more than 30 hours of service provided. In special situations where a family has chosen to "bank" respite hours to use a lump sum at one time then the authorization would need to be updated for that single month to reflect the increase. Families should not make a regular practice of this as they need to use a waiver service monthly to remain on Waiver.

Individual Provider Record of Services MC-37-ES

DHHS

Division of Medicaid and Long-Term Care / División de Medicaid y Cuidado de Largo Plazo
Provider Record of Services / Registro del Proveedor a Servicios

This Record of Services is a legal document completed by you to record the dates and units of service provided. Both the provider and the client must sign and date this record verifying the accuracy of this information. A description of services provided must be recorded daily and the total units noted. This Record of Services with the billing document must be submitted within 90 days of service and can be submitted semi-monthly or monthly. Return this Record of Services with the billing document to your specified worker. The Provider is responsible for keeping records for six years.
Este registro de servicios es un documento legal efectuado por usted para registrar las fechas y unidades de servicio prestados. Tanto el proveedor como el cliente deben firmar y fechar este registro verificando la exactitud de esta información. Una descripción de los servicios prestados debe ser registrada diariamente y debe anotarse el total de las unidades. El Registro de Servicios con el documento de facturación deben ser enviados dentro del plazo de 90 días del servicio, y pueden ser enviados quincenalmente o mensualmente. Regrese este Registro de Servicios con el documento de facturación a su trabajador asignado. El Proveedor es responsable de mantener los registros por seis años.

Client's Name / Nombre del Cliente	Client's ID Number / # de Identificación del Cliente	Provider Name / Nombre del Proveedor
John Doe	12345	Clarinda Happy
Service Provided: Servicio Prestado: Child Care/Cuidado Infantil (9704) In-Home Child Care/Cuidado Infantil en el Hogar (2500) Chore/Quehaceres (1691)	Home Again (8234) Independence Skills Building//Desarollo de Destrezas para la Independencia (8382) In-Home Independence Skills Building/ / Desarollo de Destrezas para la Independencia en el Hogar (9233)	Respite/Relevo para el descanso del cuidador (7395) In-Home Respite/Relevo para el descanso del cuidador en el hogar(1113)

Month/Mes September — Year/Año 2014

Date/ Fecha	Service Code/ Código del Servicio	Time in and out/Tiempo de incio y de Fin			Description of Authorized Services Provided/ Descripción de los Servicios Autorizados Prestados	Hourly Units Unidades de Hora	Partial Day Units/ Unidades de Día Parciales	Daily Units/ Unidades diarias	Occurrence units / Unidades de frecuencia
9-16-14	1113	In/Incio Out/Fin	12:00 pm 2:00 pm		Respite care in John's home	2			
9-17-14	2500	In/Incio Out/Fin	7:30 am 5:00 pm		Child Care	9.5			
9-18-14	2500	In/Incio Out/Fin	7:30 am 5:00 pm		Child Care	9.5			
9-19-14	2500	In/Incio Out/Fin	11:00 am 3:00 pm		Child Care	4			
		In/Incio Out/Fin							
		In/Incio Out/Fin							
		In/Incio Out/Fin							
		In/Incio Out/Fin							
		In/Incio Out/Fin							
		In/Incio Out/Fin							
		In/Incio Out/Fin							
		In/Incio Out/Fin							
		In/Incio Out/Fin							
		In/Incio Out/Fin							
		In/Incio Out/Fin							
		In/Incio Out/Fin							

I hereby certify that the above hours/days are correct and accurate and understand that fraudulent claims may result in prosecution. Por medio de la presente doy fe de que las horas/ días arriba anotados son correctos y exactos, y entiendo que las reclamaciones fraudulentas pueden resultar en una acción penal.

Clarinda Happy	9-30-14	123456789	Parent Doe	9-30-14
Signature of Individual Providing Services/Firma del Proveedor	Date/Fecha	Provider Number/Número del Proveedo	Client/Guardian Signature/Firma del Cliente/Guardián	Date/Fecha

DISTRIBUTION: WHITE; attach to billing document/Copia Blanca; adjunte a la factura YELLOW; Provider/Copia Amarilla; Proveedor PINK; Client/ Copia Rosada; Cliente TSU 7/13 MC-37-ES (52037) 9/13

- All areas must be completed
- Like the billing document, if there are blank areas the forms must be returned to the provider and ONLY the provider for correction and re-submission.
- SCs should pay close attention to the column where services were totaled as this may require correction if the provider entered the total hours into the partial day, daily, or occurrence columns.
- Be sure to thoroughly examine all documents before returning to the provider so all corrections can be made at one time then re-submitted for your review.
- All signatures on billing documents must be complete signatures, initials are not sufficient to be considered a signature.
- At times providers are assisting a family informally prior to being authorized as a care provider. In these instances the family can privately pay the provider for all dates of service prior to the provider being authorized as a Waiver provider.

- Waiver cannot reimburse for services provided before the provider enrollment process was completed and the provider became authorized to provide waiver services.
- In other instances a provider may be terminated for various reasons and cannot bill for any services provided after the effective date of termination.

Monitoring

Service Coordinators are required to make regular monthly contact (by phone or in person) with in-person visits at least every third month with a client/responsible party to evaluate the effectiveness of the IFSP and the quality of the services provided. All in person contacts shall be at a time, date and location convenient to the client/family. The services coordinator should ensure by both client and family interview and observation the formal and information supports and services being provided continue to meet the child's and family's needs, and revise the IFSP accordingly. The IFSP should be reviewed monthly to ascertain the child/family needs, including service usage and cost, and revise the IFSP to meet newly identified needs, by developing/revising outcomes and refining action steps to achieve the family goals. The services coordinator shall document any provider change in the case narrative.

At least one waiver service should be used each month. If waiver services are not being used on a monthly basis the Services Coordinator should determine if there is still a need for the child to be on the waiver.

Service Coordinators should determine whether a reassessment of the child's level of care and strengths, needs, and resources is necessary if information is received that the care needs of the child have changed. A reassessment may also be initiated based upon the services coordinator's observation of the child's functioning (either improvement or decline) during a routine services coordinator contact. If a reassessment is completed and the child remains NF level of care, a new plan of services and supports must be developed.

Contacts are documented in CONNECT in the narrative section of EDN. Narratives include the condition of the client and their living conditions. It includes any medical, social or provider issues the client may have, **provides evidence IFSP was reviewed, and client/guardians satisfaction with waiver services**. It addresses follow-up needed from prior visits/goals. Narratives also include communication with client/family/guardian and service providers; services coordinator decisions and actions; and other factual information and services coordination activity relevant to the case. Narrative documentation must be objective and free from bias.

Changes required in the IFSP evolve from the information gathered dyring the SC contacts.

CONNECT Information: Refer to Adding, Editing and Finalizing Narratives in the CONNECT Manual for information about waiver narratives

Incident Reports

A Local Level Incident Form should be completed on CONNECT each time there is a critical event or incident with a waiver child. Critical event/Incidents are any event that bring harm or risk of harm to the child including abuse, neglect, and exploitation or licensing violation. A child may experience a critical

event outside of waiver services, which may not involve authorized caregivers. Any critical event must be reported to appropriate authorities to conduct follow up action. Abuse/Neglect/Exploitation is reported to Child Protective Services/Law Enforcement. Licensing violations is reported to DHHS Division of Public Health Unit for Licensing (ex. Licensed child care). Parents are not part of the decision process when deciding whether or not to report abuse or neglect. If a child is harmed or placed at risk of harm the event must be reported. You may not be the reporter, however you still need to submit an incident report in CONNECT.

CONNECT INFORMATION: Local Level Incident Forms are to be filled out in CONNECT. The Local Level Complaint Form is accessed from the Waiver Case Page. (See Adding and Completing a Local Level Incident Form in the CONNECT instruction manual) paper copies are not used.

Complaints

Local Level Complaints record problems and issues clients have with the waiver services provider or accessing waiver services they have been authorized to receive that are likely to result in actions against the provider. For EDN clients, only parents or legal guardians can report a complaint. Complaints are submitted on CONNECT.

The complaint process is for waiver services only, and does not address non-waiver services.

CONNECT INFORMATION: Local Level Complain Forms are to be filled out in CONNECT. The Local Level Complaint Form is accessed from the Waiver Case Page. (See Adding and Completing a Local Level Complaint Form in the CONNECT instruction manual) paper copies are not used.

Notifying of Adverse Decisions

Persons who request, apply for, or receive services may appeal any adverse action or inaction. These may include, but are not limited to a potential waiver client being denied services, a waiver client's services being reduced, or a waiver client determined ineligible for waiver services. The services coordinator shall send written notice (HHS-6) of denial, reduction, or termination of services to the client/guardian. Notice to clients/guardians must contain:

- Clear statement of the action to be taken
- Clear statement of the reason for the action
- Specific policy reference which supports the action
- A complete statement of the guardian’s right to appeal

The HHS-6 must be mailed at least ten calendar days before the effective date of action. Exception: If the termination of waiver services is because of loss of Medicaid eligibility, the effective date of the termination must match the effective date of the termination of Medicaid eligibility.

Appealing Decisions/Actions

Families may appeal any adverse action, such as

- Refusal to accept a request for waiver assessment;
- Failure to act upon a request within the mandated time period;

- Failure to offer the choice between Home and Community-Based Waiver Services and NF services;
- Denial of eligibility;
- Denial, termination, or reduction of services
- Termination of the waiver case.

If a client would like to appeal a decision, they will file a DA-6 Form (written appeal request) within the timeline indication of the Notice of Adverse Action (HHS-6). The form can be emailed to DHHS.MedicaidAppeals@Nebraska.gov or mailed to NE DHHS Legal Services PO Box 95026 Lincoln NE 68509-5026

If you receive an appeal request verbal or a written note/letter asking for an appeal, a copy of the Notice of Action (HHS-6), along with the Request for Fair Hearing/written appeal document DA-6, must be forwarded to the Hearing Office. The hearing office sets the hearing date, when they receive the hearing request. Most hearings are heard via telephone, however the family always has the option to appear in person. A notice is sent from legal services to all involved parties informing them of the date, time, place, call in number and instructions for notifying DHHS Legal Services if either party is unable to attend at the scheduled time. The Hearing Officer may at his/her discretion grant extension of time or continuance for good cause shown (465 NAC 6-006.03). The Hearing Office will send instructions to the SC and family in the Notice of Hearing. The Notice provides all the information needed for the hearing.

Services Coordinator's Role

The SC must prepare for the Hearing prior to the Hearing date unless the appeal is related to the Level of Care determination. The SC is required to collect all Documentary Evidence and Create a Case Summary to submit to the Hearing Officer and the family within the time frame noted on the Notice of Hearing. The exhibits and the case summary need to be submitted to Legal Services at least 10 business days prior to the hearing date. The Central Office Program Specialist – Pediatric RN represents DHHS in all administration hearings based on the child not meeting nursing facility level of care.

All contracted staff attend hearing in their professional capacity and represent the Department's regulations. It is important to answer any questions objectively. The SC attends the hearing in a professional capacity and enters into the record what actions were taken and which regulations were followed in taking the actions. When the SC receives the Order of Finding it is important to read the Order thoroughly. Immediately take the appropriate case actions based on the ruling. Any questions should be directed to a supervisor or HCBS Waiver Program Coordinator. If a family loses their appeal with DHHS, they can file a petition in the District Court of the county where the action was taken.

Documentary Evidence

A Case Summary, a brief memo outlining events, dates and other facts involved in the case, and all documentary evidence must be submitted to Legal Services at least 10 business days prior to the hearing date. All exhibits should be numbers and listed on the Exhibit List which must accompany appeal exhibit submission. Exhibits must be submitted to DHHS.HearingOffice@Nebraska.gov. A copy of the original notice sent to the client or application must be submitted as evidence. Failure to include the notice as an exhibit can affect the outcome of the appeal. Narrative that are relevant and current to substantiate the action(s) that has been appealed are included as evidence. Additional evidence to included: copies of the Level of Care, IFSP, Waiver Worksheet, or any other pertinent documents that

substantiate the action(s) being appealed, copies of state regulation and/or manual reference which were used to justify the action being appealed, submit only documents related to the actions being appealed. The evidence can be submitted to the Hearing Office electronically or in hard copy. When you submit the documentary evidence to the Hearing Office, send a copy of everything to the client, and one copy for the SC to refer to during the hearing, which will be placed in the case file after the hearing.

If a family wishes to withdraw their Hearing request, the Hearing Office needs to receive notification in writing from the family or the applicant. Once the notification has been received, the Hearing is dismissed. A written Order of Dismissal is sent to all involved parties. If the client cannot attend the hearing at the scheduled time, the family must contact Legal Services so an Order of Continuance can be requested. If the hearing is rescheduled, a written Order is sent from Legal to make certain everyone knows there has been a change.

The SC is responsible to call in / attend the Hearing if the SC is aware the client is not going to appear. If the family fails to attend or call in for their Hearing, the Hearing Office may issue an Order dismissing the case. However, if the family contacts the Hearing Officer and has good cause for missing the Hearting, an Order of Continuance may be issued and the Hearing held at a different day and time.

Hearing Office/Legal Services can be reached at DHHS.LegalHearing@Nebraska.gov or Nebraska Department on Health and Human Services Legal Services PO Box 95026, Lincoln NE 68509-50236, Phone 402-471-7237 Fax 402-742-2376

Waiver Glossary

Agency Provider: Providers who have one or more employees or will be subcontracting any one or part of the service(s) for which they are requesting approval.

Cap: The average Medicaid monthly expenditure for care in a NF. This dollar amount is referred to as "the cap."

Caregiver: A person who resides with the client and is available on a 24-hour per day basis to assume responsibility for the care and supervision of the client. This may include a caregiver who is employed outside the home if s/he retains "on-call" responsibility while away from the client.

Case Summary: a brief memo outlining events, dates and other facts involved in the case.

Child: For the purposes of Medicaid and this waiver, an individual age 17 or younger.

Client Relatives as Providers: Legally responsible relatives (i.e., spouses of clients or parents of minor children who are clients) shall not be approved as service providers for their relatives.

Conflict of Interest: No employee of HHS or its subdivisions may be approved as a service provider if s/he is in a position to influence his/her own approval or utilization.

Cost Effective: A requirement that the expenditures reflected in the Plan of Services and Supports be within "the cap" and also reflect a service rate appropriate for the client's individualized service need.

Critical event/Incidents: any event that bring harm or risk of harm to the child including abuse, neglect, and exploitation or licensing violation.

Guardian: The biological or adoptive parent of a minor child, or an individual appointed by a court to ensure that an adult's needs are met and well-being is protected.

HHS-6: written notice of denial, reduction, or termination of services to the client/guardian which contains a clear statement of the action to be taken, a clear statement of the reason for the action, a specific policy reference which supports the action, and a complete statement of the guardian's right to appeal.

HHS Staff Relatives as Providers: HHS staff shall not approve, reapprove, evaluate, or negotiate provider agreements with, or authorize service provision from, providers to whom they are related. In situations where a HHS staff person's relative is the only resource, staff shall obtain approval from the Service Area Administrator or designee.

Home and Community Based Waiver Services (HCBS): Home and community-based waiver services offer eligible persons a choice between entering a Nursing Facility (NF) or receiving supportive services in their homes.

Individual Provider: Providers who have no employees and will not normally be subcontracting any service(s) for which they are requesting approval. Individual providers are independent contractors and not employees of HHS or the State of Nebraska. (For the purpose of FICA withholding, the provider is considered an employee of the client.)

Initial Assessment Date: Date the Parent / SC meet and draft IFSP cover page, Needs/Priorities, present levels of Development/Abilities pages

Institutional Setting: A hospital or a nursing facility.

Medicaid Eligibility Status:
Pending: default date as Waiver Eligibility Pending date
Opened: Date SSW opened Medicaid on N-FOCUS

Nursing Facility (NF): A facility licensed by the Department of Health and Human Services Regulation and Licensure as a nursing facility.

Nursing Facility Level of Care: A child has medical needs sufficient to qualify them for admission to a nursing facility

Parent Obligation: The parent or primary caregiver is responsible for the basic cost of routine child care

Plan of Services and Supports: A process for providing services and supports that takes into consideration each client's strengths, needs, priorities, and resources and results in an individualized, written plan for each client. This plan describes the full range of services to be furnished (regardless of funding source), their frequency, and the type of provider who will furnish each.

Provider Identification Number: A nine-digit federal identification (FID) number

Referral Date: Date the Parent/Guardian expressed interest to Services Coordinator in applying for waiver services

Services Coordination: An individualized, goal-oriented process, based on client choices, which makes the best use of resources to maximize independence and attain the level of care that is consistent with the client's level of need. Services coordination is federally referred to as case management.

Service Provider Agreement: A legally binding document which may include an addendum and all applicable provider checklists, describing the service(s) to be provided, and the maximum rate(s) allowed for each provider. The responsibilities of the provider and of HHS are stated in the agreement.

Slots: Nebraska's quota of waiver clients.

Waiver: Nebraska's Home and Community-Based Waiver for Aged Persons or Adults and Children with Disabilities.

Waiver Eligibility Status:
Pending: Date parent/guardian expresses interest to SC in applying for waiver
Opened: Date consent for waiver services signed by parent/guardian